INSTRUCTIONS ON REVERSE SIDE)
FOR USE BY
PHYSICIANS AND
MEDICAL EXAMINERS

The Commonwealth of Massachusetts

STAN. CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

REGISTERED NUMBER | STATE USE ONLY

STATE USE ONLY

DECEDENT

DECEDENT - NAME FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)
1 Nancy	J.	Higgins	2 F	3 July 3, 2001

PLACE OF DEATH (City/Town):	COUNTY OF DEATH	HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)
4a Dennis	4b Barnstable	4c Eagle Pond Rehabilitation & Living Center

PLACE OF DEATH (Check only one): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA | OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify) | SOCIAL SECURITY 5 469-5: 6

EXHIBIT 10

WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.)	RACE (e.g. White, Black, American Indian, etc.) (Specify)	DECEDENT'S Elementa
☒ NO ☐ YES 8a Specify:	8b White	9

AGE - Last Birthday (Yrs.)	UNDER 1 YEAR MOS.	DAYS	UNDER 1 DAY HOURS	MINS	DATE OF BIRTH (Mo., Day, Yr.)	BIRTHPLACE (City and State or Foreig
10a 54	b		c		10d June 27, 1947	11 Glen Ridge,

MARRIED, NEVER MARRIED WIDOWED OR DIVORCED	LAST SPOUSE (If wife, give maiden name)	USUAL OCCUPATION (Prior - If Retired)	KIND OF BUSINESS OR INDUSTRY
12 Divorced	13 Carl Higgins	14a Self-employed	14b Residential Cleaner

RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY: 15a 1 Love Lane, Dennis, Barnstable, Massachusetts | ZIP CODE 15b 02660

FATHER - FULL NAME	STATE OF BIRTH (If not in US, name country)	MOTHER - NAME (GIVEN) (MAIDEN)	STATE OF BIRTH (If not in the US, name country)
16 Alan Conklin	17 New Jersey	18 Martha Scarborough	19 Ohio

INFORMANT

INFORMANT'S NAME	MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE	RELATIONSHIP
20 Christine Jeffreys	21 125 Otey Drive, Meridianville, AL 35759	22 Sister

DISPOSITION

23 METHOD OF IMMEDIATE DISPOSITION	FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE	LICENSE #
☒ BURIAL ☐ CREMATION ☐ ENTOMBMENT ☐ REMOVAL FROM STATE ☐ DONATION ☐ OTH. SPEC.	24 John T. Blute	25 6527

PLACE OF DISPOSITION (Name of Cemetery, Crematory or other)	LOCATION (City/Town, State)
26a Orleans Cemetery	26b Orleans, Massachusetts

DATE OF DISPOSITION (Mo., Day, Yr.)	NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE
27 July 6, 2001	28 Nickerson Funeral Home, 77 Eldredge Park Way, Orleans, MA 02653

CERTIFIER

29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a End Stage Chronic Obstructive DUE TO (OR AS A CONSEQUENCE OF)	Years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b Lung Disease DUE TO (OR AS A CONSEQUENCE OF)	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d	

PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.	WAS AUTOPSY PERFORMED? (Yes or No)	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
30	31 No	32

MED. EXAM. NOTIFIED? (Yes or No)	34 MANNER OF DEATH	DATE OF INJURY (Mo., Day, Yr.)	TIME OF INJURY	INJURY AT WORK (Yes or No)
33 No	☐ NATURAL ☐ HOMICIDE ☐ COULD NOT BE DETERMINED ☐ ACCIDENT ☐ SUICIDE ☐ PENDING INVESTIGATION	35a	35b M	35c

DESCRIBE HOW INJURY OCCURRED	PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.,) Specify	LOCATION (No. & St., City/Town, State)
35d	35e	35f

To be Completed by CERTIFYING PHYSICIAN ONLY

36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title) Arthur F. Bickford

DATE SIGNED (Mo., Day, Yr.)	HOUR OF DEATH
36b July 3 2001	36c 10:20 M

NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER: 36d

To be Completed by MEDICAL EXAMINER ONLY

37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title)

DATE SIGNED (Mo., Day, Yr.)	HOUR OF DEATH
37b	37c M

PRONOUNCED DEAD (Mo., Day, Yr.)	PRONOUNCED DEAD (Hr)
37d	37e M

NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print): 38 Arthur F Bickford MD 714 Main St 02675 Yarmouthport Ma | LICENSE NO. OF CERTIFIER 39 28631

WAS THERE A PRONOUNCEMENT FORM? (Yes or No)	IF YES, DATE PRONOUNCED	IF YES, TIME PRONOUNCED	40d NAME OF PRONOUNCER	TITLE
40a Yes	40b July 3, 2001	40c 10:20P M	Joan Donna Foley	☒ R.N. ☐ P.A.

DATE BURIAL PERMIT ISSUED	RECEIVED IN THE CITY/TOWN OF	DATE OF RECORD
SIGNATURE OF HEALTH AGENT 41 July 6, 2001	CLERK'S SIGNATURE 42 Dennis Jacquelyn K. Souza	43 July 6, 2001

Pronouncement of Death Form (R-302) on File: ☒

PERMANENT BLACK INK ONLY

301-00

"I, the undersigned, hereby certify that I am the Clerk of the Town of Dennis; that, as such, I have custody of the records of births, deaths and marriages required by law to be kept in my office; I do hereby certify that the above is a true copy from said records."

Jacquelyn K. Souza
DENNIS TOWN CLERK